
 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-499-1275 or visit us at [www.excellusbcbs.com/IBEW910](http://www.excellusbcbs.com/IBEW910). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$250/Individual or \$500/Family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> and <a href="#">out-of-network providers</a> \$1,000 per individual.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> .
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Deductibles</a> , <a href="#">Copayments</a> , <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.excellusbcbs.com/IBEW910">www.excellusbcbs.com/IBEW910</a> or call 1-800-499-1275 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> , up to allowable amount.	Subject to deductible
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> , up to allowable amount.	Subject to deductible
	<a href="#">Preventive care/screening/immunization</a>	No charge	20% <a href="#">coinsurance</a> , up to allowable amount.	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> , up to allowable amount.	Subject to deductible
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> , up to allowable amount.	Subject to deductible
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.savrx.com">www.savrx.com</a> .	Generic drugs	20% <a href="#">coinsurance</a> (Retail & Mail order)	Not Covered	<b>Retail</b> prescriptions limited to 30-day supply.  <b>Mail order</b> prescriptions limited to 90-day supply.
	Preferred brand drugs	20% <a href="#">coinsurance</a> (Retail & Mail order)	Not Covered	
	Non-preferred brand drugs	20% <a href="#">coinsurance</a> (Retail & Mail order)	Not Covered	
	Specialty drugs	20% <a href="#">coinsurance</a> (Retail & Mail order)	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No Charge	20% <a href="#">coinsurance</a> , up to allowable amount.	None
	Physician/surgeon fees	No Charge	20% <a href="#">coinsurance</a> , up to allowable amount.	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	No Charge	20% <a href="#">coinsurance</a> , up to allowable amount.	None
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> , up to allowable amount.	Subject to deductible
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> , up to allowable amount.	Subject to deductible

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% <a href="#">coinsurance</a> , up to allowable amount.	None
	Physician/surgeon fees	No Charge	20% <a href="#">coinsurance</a> , up to allowable amount.	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> , up to allowable amount.	<b>Outpatient mental/behavioral services</b> are subject to deductible. <b>Outpatient substance abuse services</b> are covered in full for a network provider.
	Inpatient services	No Charge	20% <a href="#">coinsurance</a> , up to allowable amount.	None
If you are pregnant	Office visits	No Charge	20% <a href="#">coinsurance</a> , up to allowable amount.	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No Charge	20% <a href="#">coinsurance</a> , up to allowable amount.	
	Childbirth/delivery facility services	No Charge	20% <a href="#">coinsurance</a> , up to allowable amount.	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No Charge	20% <a href="#">coinsurance</a> , up to allowable amount.	None
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> , up to allowable amount.	Subject to deductible. Limit: Physical, Occupational and Speech Therapy – 20 visits per calendar year, per therapy.
	<a href="#">Habilitation services</a>	See Rehabilitation services	See Rehabilitation services	See Rehabilitation services
	<a href="#">Skilled nursing care</a>	No Charge	20% <a href="#">coinsurance</a> , up to allowable amount.	None
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> , up to allowable amount.	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	<a href="#">Hospice services</a>	No Charge	20% <a href="#">coinsurance</a> , up to allowable amount.	Limited to 210 days per lifetime.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not covered	Not Covered

## Excluded Services & Other Covered Services:

### Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Acupuncture
- Cosmetic Surgery
- Dental Care
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Routine eye care (Adult)
- Routine Foot Care
- Weight Loss Programs

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Bariatric Surgery
- Chiropractic Care – Limited to 40 visits per calendar year
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing – Limited to 30 visits per calendar year

**Your Rights to Continue Coverage:** For more information on your rights to continue coverage, contact the IBEW Local 910 Fund Office at 1-800-801-2201. There are also agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform); Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: the phone number on Your ID card or; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform); New York State Department of Financial Services Consumer Assistance Unit at 1-800-342-3736 or [www.dfs.ny.gov](http://www.dfs.ny.gov). Additionally a consumer assistance program can help you file your [appeal](#). Contact the Consumer Assistance Program at 1-888-614-5400, or e-mail [cha@cssny.org](mailto:cha@cssny.org) or [www.communityhealthadvocates.org](http://www.communityhealthadvocates.org). A list of states with Consumer Assistance Programs is available at: [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) and [www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants](http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants).

### Does this plan provide Minimum Essential Coverage? **Yes.**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### Does this plan meet Minimum Value Standards? **Yes.**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

---

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$250
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 20%

**This EXAMPLE event includes services like:**

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,820</b>
---------------------------	-----------------

**In this example, Peg would pay:**

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$80
<b>The total Peg would pay is</b>	<b>\$80</b>

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$250
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 20%

**This EXAMPLE event includes services like:**

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,460</b>
---------------------------	----------------

**In this example, Joe would pay:**

Cost Sharing	
Deductibles	\$250
Copayments	\$0
Coinsurance	\$90
What isn't covered	
Limits or exclusions	\$370
<b>The total Joe would pay is</b>	<b>\$710</b>

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$250
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 20%

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,970</b>
---------------------------	----------------

**In this example, Mia would pay:**

Cost Sharing	
Deductibles	\$250
Copayments	\$0
Coinsurance	\$80
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$330</b>

*Note: This plan is integrated with a Health Reimbursement Arrangement ("HRA"). Deductibles, copayments and other qualified out-of-pocket expenses may be reimbursable under the HRA.*